

## February 20, 2022 E-Newsletter

### Alliance Cheers House Passage of Bipartisan Postal Reform Bill

On Wednesday the U.S. House of Representatives passed **H.R. 3076, the 2021 Postal Reform Act**, on a bipartisan **342-92** vote, repealing the Congressional mandate that the United States Postal Service (USPS) spend billions of dollars every year to prefund retiree health care. The Postal Service would instead pay these costs on a yearly basis, as other government agencies and corporations do, saving nearly \$50 billion over 10 years. In addition, the bill would mandate that the USPS continue to deliver

the mail at least six days each week.

The Alliance for Retired Americans, the American Postal Workers Union (APWU), the National Association of Letter Carriers (NALC), the National Postal Mail Handlers Union (NPMHU), the National Rural Letter Carriers' Association (NRLCA), and the AFL-CIO all support the legislation.

Majority Leader Chuck Schumer (NY) said he will hold a vote on the bill in the Senate as



soon as possible. White House officials have said that President Biden would then sign it into law, putting the Postal Service on more solid financial footing.

APWU and the Alliance are asking members to help by calling your Senators at 844-402-1001 and urging them to vote "YES" on The Postal Service Reform Act of 2022. Tell them that passage of the Postal Reform Act of 2022 will help solve many of the USPS financial challenges, is fair to active and retired postal

workers, and is a big step toward strengthening and preserving our public Postal Service.

"Older Americans rely on the U.S. Postal Service for at-home delivery of medications and important mail six days a week," said Robert Roach, Jr., President of the Alliance. "It is an institution that has served our country since its founding, and it is as important today as it ever was."



Robert Roach, Jr.  
 President, ARA

### Census Report Highlights Older Households' Sources of Income

While Social Security makes up the largest share of most older adults' incomes, other sources also provide earnings to people 65 and older. A new **report** from the United States Census Bureau analyzed older households' sources of income, the amounts, and how much each source contributed to total household income. The analysis relied upon data from the nationally representative 2018 Survey of Income and Program Participation (SIPP), which reflected respondents' answers about their incomes from 2017.

The report examined six types of income primarily earned by people aged 65 or older,

including Social Security, Supplemental Security Income (SSI), pension and retirement account income, property income, earnings and other income.

The average total income for households with only people aged 65 or over was \$41,830 in 2017. The average Social Security income for those households was \$18,250, with Social Security providing 57.5% of overall income. The report found that 20.4% of adults 65+ still worked.

As expected, lower-income households relied primarily on program income sources such as Social Security and SSI.

Meanwhile, higher-income households were reported to receive more of their income from pensions, retirement accounts and assets held outside of a retirement account.

"The data is a useful reminder about how much of seniors' income comes from Social Security and is important for determining what we need to do to improve retirement security," said Richard Fiesta, Executive Director of the Alliance. "By strengthening and expanding Social Security and continuing to defend pensions from attack, we can help ensure that seniors will enjoy a dignified retirement after a lifetime of hard work."

"Of course, we must also get health care and prescription drug costs under control," he added. According to **Stat**, the out-of-pocket costs that Medicare enrollees faced at the pharmacy counter accounted for approximately 12% of their **median income as of 2019** — and that did not even account for other out-of-pocket medical expenditures such as drug plan and other insurance plan premiums, or for treatment of many other acute or chronic illnesses



Rich Fiesta,  
 Executive Director, ARA

### Health Care Paradox: Medicare Penalizes Dozens of Hospitals It Also Gives Five Stars

**KHN** KAISER HEALTH NEWS The federal government has penalized 764 hospitals — including more than three dozen it simultaneously rates as among the best in the country — for having the highest numbers of patient infections and potentially avoidable complications.

The penalties — a 1% reduction in Medicare payments

over 12 months — are based on the experiences of Medicare patients discharged from the hospital between July 2018 and the end of 2019, before the pandemic began in earnest. The punishments, which the Affordable Care Act requires be assessed on the worst-performing 25% of general hospitals each year, are intended to make



**Medicare**

hospitals focus on reducing bedsores, hip fractures, blood clots, and the cohort of infections that before covid-19 were the biggest scourges in hospitals. Those include surgical infections, urinary tract infections from catheters, and antibiotic-resistant germs like MRSA.

This year's list of penalized hospitals includes Cedars-Sinai

Medical Center in Los Angeles; Northwestern Memorial Hospital in Chicago; a Cleveland Clinic hospital in Avon, Ohio; a Mayo Clinic hospital in Red Wing, Minnesota; and a Mayo hospital in Phoenix. Paradoxically, all those hospitals have five stars, the best rating, on **Medicare's Care Compare website... Read More**

ADD YOUR NAME

**Get The Message Out: SIGN THE GPO/WEP PETITION!!!!**

# Medicare Rights Joins 90 Organizations Urging Senate to Pass Drug Pricing Reforms

This week, over 90 advocacy and other organizations **sent a letter to U.S. Senators**, urging them to pass the drug pricing reforms included in the House-passed **Build Back Better (BBB) Act (HR 5376)**. These policies would allow Medicare to negotiate some drug prices, limit annual price increases on drugs to the rate of inflation, limit cost sharing for insulin, and restructure the Part D prescription drug program to cap out-of-pocket costs.

The Kaiser Family Foundation (KFF) recently **looked at the potential effects** of the BBB's drug price negotiation proposal. As currently structured, it would be phased in and apply to a limited number of drugs. Beginning in 2025, Medicare

would be allowed to negotiate prices for all insulin products and up to 10 other drugs, drawn from a list of the 50 drugs with the highest spending in Medicare Part D and Part B. The number of drugs subject to negotiation would increase each year, until reaching 20 in 2028. Since this provision would not be fully implemented until then—making it impossible to know exactly what drugs would be eligible for negotiation—KFF identified the drugs that would be if the law were in place in 2023 instead. Their analysis calculates a simulated effect based on that list.

KFF's simulation found that the 20 negotiated drugs—selected based on eligibility and



total gross spending—would include 18 Part D drugs and 2 Part B drugs, in addition to 42 insulin products. Many of the drugs are commonly used, with 3.2 million people using one of the covered insulin products, and **1.1 million people each using Xarelto and Symbicort**, drugs that treat blood clots and chronic obstructive pulmonary disease (COPD). KFF estimates that 8.5 million people with Medicare use one or more of the drugs that would be eligible for negotiation.

Importantly, the structure of the BBB provisions would exempt some of the highest-cost drugs from negotiation. As KFF notes, drugs with generic or biosimilar competitors would be

exempt, as would those that are relatively new to the market. It is also significantly scaled back: previous House-passed policies sought to allow negotiation for up to 250 drugs.

Nevertheless, the bill is a significant advancement. The Congressional Budget Office **estimated that the provision would save Medicare \$80 billion**. At Medicare Rights we believe it's important to begin making progress on drug pricing and, in combination with the other provisions of the BBB, some drug price negotiation would be a major step toward reining in prescription costs for people with Medicare. We urge Congress to prioritize these reforms for passage this year.

**Read the letter.**

## Mark Cuban launches low-cost drug pharmacy

Imagine a closet filled with treasures accumulated during a lifetime of rich experiences. Now, imagine going into that closet to find one specific object. The big news this week on the drug pricing front is that Mark Cuban has launched a low-cost generic drug pharmacy. Helaine Olen reports for **The Washington Post** that Cuban will charge just the cost of manufacturing a generic drug plus 15 percent and a \$3 processing fee. Believe it or not, **Cuban's CostPlus Drugs** online pharmacy could save some people hundreds, if not thousands, of dollars.

I wish I could explain how Mark Cuban is selling generic drugs at significantly lower prices than you will ever find at

your local pharmacy. But, the great news is that he somehow is.

And, he has created a Pharmacy Benefit Manager so that, over time, drugs his company sells should be covered by your insurance. Right now though, your insurance won't cover drugs you buy from his company.

Cuban's prices are so low for some generic drugs, that his online pharmacy can mean the difference between life and death for some people. Even if you have insurance, you might be able to save a fortune relative to what your copay would be with your insurance and get the drugs you need. People who do



not have insurance of course also can benefit from Cuban's drug company. For example, CostPlus Drugs charges \$17.10 a month for imatinib, the generic of the cancer drug Gleevec, even though its typical price could easily be more than \$2,500 a month.

Cuban is planning ahead to control drug prices. He is building a prescription drug manufacturing site that will help ensure his generic drugs are as low-cost as possible. Today, the federal government **reports** that more than five million people with Medicare are struggling to afford their drugs, including 1.8 million

people with disabilities. CostPlus Drugs cannot begin to help all of them since Part D won't cover the generic drugs he sells and CostPlus cannot help people needing brand-name drugs. And, that means that many of them will **die needlessly**.

In short, Cuban's effort is a nice opening. But, Congress must step in and regulate all drug prices. Joe Manchin is blocking passage of the **Build Back Better Act**, which would regulate prices in Medicare for top-selling drugs. Since he does not appear to object to that portion of the bill, we need him to agree to vote for and allow the Democrats to pass at least that portion.

## 5 Things You Should Know About 'Free' At-Home Covid Tests

Americans keep hearing that it is important to test frequently for covid-19 at home. But just try to find an "at-home" rapid covid test in a store and at a price that makes frequent tests affordable.

Testing, as well as mask-wearing, is an important measure if the country ever hopes to beat covid, restore normal routines and get the economy running efficiently. To get Americans cheaper tests, the federal government now plans to

have insurance companies pay for them. The Biden administration **announced Jan. 10** that every person with private insurance can get full coverage for **eight rapid tests a month**. You can either get one without any out-of-pocket expense from retail pharmacies that are part of an insurance company's network or buy it at any store and get reimbursed by the insurer.



Congress said private insurers must cover all covid testing and any associated medical services when it passed the **Families First Coronavirus Response Act and the Coronavirus Aid, Relief and Economic Security, or CARES, Act**. The have-insurance-pay-for-it solution has been used frequently through the pandemic. Insurance companies have been told to pay for PCR

tests, covid treatments and the administration of vaccines. (Taxpayers are paying for the cost of the vaccines themselves.) It appears to be an elegant solution for a politician because it looks free and isn't using taxpayer money.

For more information on the five things you should know about "free" at-home covid test... **Read Here**

## Medicare Rights Client Testifies Before the Senate Special Committee on Aging

Today, a Medicare Rights Center client, Jane Doyle, testified before the U.S. Senate Special Committee on Aging about her and her family's experiences with Medicare and Medicaid. In the **hearing**, titled "Improving Care Experiences for People with both Medicare and Medicaid," she shared her perspective as someone dually eligible for both programs, and as a caregiver for her mother, who also has Medicare and Medicaid.

She explained that while the programs are important, they are not always easy to use. She recounted how she would often struggle to find providers who not only accepted Medicaid, but also understood and were willing to undertake the complex billing and administrative processes needed to obtain payment for providing her care. Ms. Doyle described her concerns that people who don't have the established relationships with providers she was fortunate enough to have,

including with providers who are willing to forgo some of their payment, may not be able to access needed care. She also expressed her worry that "since many doctors don't take the managed care, and these programs try to cut costs, the quality of care I receive suffers." As an example, she noted that during the pandemic, she had three operations, one of which resulted in irreversible nerve damage. "This resulted in me needing neurosurgery, and I had to travel 100 miles to Philadelphia to get that care."

She also talked about her mother's interactions with Medicare and Medicaid, including her eligibility and access challenges. Her mother participates in a waiver program, which provides Medicaid coverage for Home- and Community-Based Long-Term Care Services and Supports (LTCSS). Accessing these services in her home,



instead of having to move to a nursing home, was her preference, and Ms. Doyle and her family wanted to honor that. Unfortunately, the process to get into that program was onerous and stressful. It involved nearly depleting her mother's assets, filing often overwhelming amounts of paperwork, identifying and coordinating with a provider willing to oversee the case, and finding a participating home health care agency able to meet her mother's needs. As she told the Committee, "We had to complete hundreds of documents for my mother's application. Eventually, we didn't have enough money to pay for one more day of care."

Finally, Ms. Doyle talked about her frustration and worry that she would not be able to purchase a supplemental Medigap plan to provide coverage for her out-of-pocket expenses if she were to lose Medicaid. Because she had

Medicaid when she was first eligible for Medicare, she is, in a way, "trapped" in Medicaid — she cannot increase her income or savings for fear of losing Medicaid's important protection against unlimited out-of-pocket costs. Ms. Doyle asked the Committee to continue to pay attention to the needs of people who have Medicare and Medicaid, and to pass laws that will make accessing care and coverage less onerous and less precarious for people like herself and her mother. "To make these programs actually work, it needs to be much easier for people like my mother to enroll and for people like me to find care," she said.

Medicare Rights is grateful to Ms. Doyle for testifying before the Committee. We will strive to honor her and her family's experience by advocating for policy changes that strengthen and simplify Medicare and Medicaid.

**[Read her testimony.](#)**

## Why Millions on Medicaid Are at Risk of Losing Coverage in the Months Ahead

The Biden administration and state officials are bracing for a great unwinding: millions of people losing their Medicaid benefits when the pandemic health emergency ends. Some might sign up for different insurance. Many others are bound to get lost in the transition.

State Medicaid agencies for months have been preparing for the end of a federal mandate that anyone enrolled in Medicaid cannot lose coverage during the pandemic.

Before the public health crisis, states regularly reviewed whether people still qualified for the safety-net program, based on their income or perhaps their age or disability status. While those routines have been suspended for the past two years, enrollment climbed to record highs. As of July, 76.7 million people, or nearly 1 in 4 Americans, were enrolled, according to the Centers for Medicare & Medicaid Services.

When the public health emergency ends, state Medicaid officials face a huge job of reevaluating each person's eligibility and connecting with people whose jobs, income, and housing might have been upended in the pandemic. People could lose their coverage if they earn too much or don't provide the information their state needs to verify their income or residency.

Medicaid provides coverage to a vast population, including seniors, the disabled, pregnant women, children, and adults who are not disabled. However, income limits vary by state and eligibility group. For example, in 2021 a single adult without children in Virginia, a state that expanded Medicaid under the Affordable Care Act, had to earn **less than \$1,482** a month to qualify. In Texas, which has not expanded its program, adults without children don't qualify for Medicaid.

State Medicaid agencies often



send renewal documents by mail, and in the best of times letters go unreturned or end up at the wrong address. As this tsunami of work approaches, many state and local offices are short-staffed.

The Biden administration is giving states a year to go through the process, but officials say financial pressures will push them to go faster. Congress gave states billions of dollars to support the coverage requirement. But the money will dry up soon after the end of the public emergency — and much faster than officials can review the eligibility of millions of people, state Medicaid officials say.

In Colorado, officials expect they'll need to review the eligibility of more than 500,000 people, with 30% of them at risk of losing benefits because they haven't responded to requests for information and 40% not qualifying based on income.

In Medicaid, "typically, there's always been some amount of folks who lose coverage for administrative reasons for some period of time," said Daniel Tsai, director of the CMS Center for Medicaid and CHIP Services. "We want to do everything possible to minimize that."

In January the eligibility of roughly 120,000 people in Utah, including 60,000 children, was in question, according to Jeff Nelson, who oversees eligibility at the Utah Department of Health. He said that 80% to 90% of those people were at risk because of incomplete renewals. "More often than not, it's those that just simply have not returned information to us," he said. "Whether they didn't receive a renewal or they've moved, we don't know what those reasons are..." **[Read More](#)**

# What Are Taxpayers Spending for Those ‘Free’ Covid Tests? The Government Won’t Say.

The four free covid-19 rapid tests President Joe Biden promised in December for every American household have begun arriving in earnest in mailboxes and on doorsteps.

A surge of covid infections spurred wide demand for over-the-counter antigen tests during the holidays: Clinics were overwhelmed with people seeking tests and the few off-the-shelf brands were nearly impossible to find at pharmacies or even online via Amazon.

Prices for some test **kits cracked the hundred-dollar mark.** And the government vowed that its purchase could provide the tests faster and cheaper so people, by simply swabbing at home, could quell the spread of covid.

The Defense Department organized the bidding and announced **in mid-January,** after a limited competitive process, that three companies

were awarded contracts totaling nearly \$2 billion for 380 million over-the-counter antigen tests, all to be delivered by March 14.

The much-touted purchase was the latest tranche in trillions of dollars in public spending in response to the pandemic. How much is the government paying for each test? And what were the terms of the agreements? The government won’t yet say, even though, by law, this information should be available.

The cost — and, more importantly, the rate per test — would help demonstrate who is getting the best deal for protection in these covid times: the consumer or the corporation.

The reluctance to share pricing details flies against basic notions of cost control and accountability — and that’s just quoting from a **long-held position by the Justice Department.** “The prices



in government contracts should not be secret,” according to its website. “Government contracts are ‘public contracts,’ and the taxpayers have a right to know — with very few exceptions — what the government has agreed to buy and at what prices.”

Americans often pay far more than people in other developed countries for tests, drugs, and medical devices, and the pandemic has accentuated those differences. Governments abroad had been buying rapid tests in bulk for over a year, and many national health services distributed free or low-cost tests, **for less than \$1,** to their residents. In the U.S., retailers, companies, schools, hospitals, and everyday shoppers were competing months later to buy swabs in hopes of returning to normalcy. The retail price climbed as high as \$25 for a

single test in some pharmacies; tales abounded of corporate and wealthy customers hoarding tests for work or holiday use.

**U.S. contracts valued at \$10,000** or more are required to be routinely posted to [sam.gov](http://sam.gov) or **the Federal Procurement Data System, known as fpds.gov.** But none of the three new rapid-test contracts — awarded to iHealth Labs of California, Roche Diagnostics Corp. of Indiana, and Abbott Rapid Dx North America of Florida — could be found in the online databases

“We don’t know why that data isn’t showing up in the FPDS database, as it should be visible and searchable. Army Contracting Command is looking into the issue and working to remedy it as quickly as possible,” spokesperson Jessica R. Maxwell said in an email in January. .

**.Read More**

## Dear Marci: *Should I enroll in Medicare if I have job-based insurance?*

Dear Marci,  
My husband still works, and I am covered by his employer’s insurance. I am turning 65 in a few months and wondering if I should enroll in Medicare?  
-Mariko (Sallisaw, OK)

Dear Mariko,  
It is great that you are looking into this ahead of time and making a plan!  
Job-based insurance allows you to delay Medicare enrollment in many cases. There are two questions to consider:

- ◆ Will I have an opportunity to enroll in Medicare Part B later without a penalty and without waiting for a specific time of year?
- ◆ Will my job-based insurance pay primary on my health care claims?

In other words, before you delay enrollment, you should determine whether you will have a **Part B Special Enrollment Period (SEP)** and whether your **job-based insurance pays primary or secondary.**

In other words, before you delay enrollment, you should determine whether you will have a **Part B Special Enrollment Period (SEP)** and whether your

**job-based insurance pays primary or secondary.**

In most cases, you should only delay Part B if you will have an SEP **and** your job-based insurance is the primary payer (meaning it pays first for your medical bills) and Medicare is secondary.

**Part B Special Enrollment Period**

Because you will be **eligible for Medicare due to age** (meaning you will be 65+) and are covered by your spouse’s job-based insurance, you will have a **Special Enrollment Period (SEP)** to enroll in Part B while you have that coverage from current work up to eight months after the coverage or the work ends (whichever is first). This means that you can enroll in Part B after your **Initial Enrollment Period (IEP)** ends without facing a penalty and without having to wait for the **General Enrollment Period (GEP).** **Primary or secondary job-based insurance**

Next, consider whether your job-based insurance will be the primary payer.

- ◆ Job-based insurance is primary



if it is from an employer with 20+ employees. Medicare is secondary in this case, and some people choose not to enroll in Part B because of the additional monthly premium.

- ◆ Job-based insurance is secondary if it is from an employer with fewer than 20 employees. Medicare is primary in this case, and if you delay Medicare enrollment, your job-based insurance may provide little or no payment. You should enroll in Part B for coverage when you are first eligible.

Note: There are different rules about the SEP and which insurance is primary if you are Medicare-eligible due to **disability** or because you have **ESRD.**

To find out if your job-based insurance is primary or secondary, contact your or your spouse’s human resources department for information about your employer’s size. If you plan to delay enrollment into Part B and use the SEP later, keep records of your health insurance coverage. You will be required to submit proof of your

enrollment in job-based insurance when using the SEP to enroll in Part B later. Proof of enrollment in job-based insurance includes:

- ◆ Written notice from your employer or plan
  - ◆ Documents that show health insurance premiums paid, including W-2s, pay stubs, tax returns, and/or receipts
  - ◆ Health insurance cards with the appropriate effective date
- Note: If you have insurance from an employer that is not because of current work, like **COBRA** or **retiree insurance,** there are different rules for the SEP and which insurance is primary. In summary, you should find out if your husband’s insurance will be primary to Medicare. If it is primary, then you can delay Medicare enrollment if you’d like, since you would already have primary insurance from your husband’s current work. I hope this helps you decide whether or not to enroll in Medicare during your Initial Enrollment Period!

-Marci

## Caregiver Support Service Programs: Are They Worth It?

Some employers are beginning to offer caregiving support services as an employee benefit. Know what to ask before opting in.

There are 50 million family caregivers in the U.S. That number is probably low considering that many people **became caregivers for the first time during the COVID-19 pandemic.** Of course, with a corresponding increase in the number of caregivers arises a corresponding increase in the media covering the issue and the number of services arising to assist family caregivers.

More employers have jumped on board to assist employee caregivers during the pandemic. For example, Google just upped their caregiver leave to eight weeks, doubling the days from its previous allowance. Pre-

pandemic, there were benchmark companies **leading the way,** changing the attitude and company culture around caregivers first that further led to providing the right benefits at the right time.

A simple add-on to employee benefit programs have been bundling caregiver support services that offer everything from personal concierge services to financial guidance to referral services. New companies offering these services are popping up monthly. I would argue some have a deep-rooted mission in helping while others simply sense a business opportunity.

Certainly, if offered as a free service by an employer, it would be something to look into; however, if your employer offers caregiver support services as a



volunteer benefit for a cost, then perhaps you need to evaluate whether it is worth the time and money exploring these options.

### **Time Off and Flexibility**

In Harvard's seminal report, **The Caring Company,** the two biggest needs for family caregivers in the workplace were time off and flexible working hours. While that report came out a few years ago, those priorities have not changed. While the country grapples for national paid time-off legislation, some employers have stepped up to offer it – some paying you during it, others just giving off the time.

The flexibility piece, one could argue, happened naturally because of COVID. Working from home, for those professions that can, certainly has helped caregivers to be more hands-on

in caring for a loved one. For many companies, permanent changes have resulted as they realize the work is still getting done and jettisoning real estate for offices has a huge financial impact.

Still, having more time does not mean knowing how to organize your time and access **the resources to be an effective caregiver.** **Caregiver burnout** if anything has probably increased as the proximity and time near a loved one has worn people out mentally and physically. So that's where these services come in.

But are caregiver support service programs rabbit holes that confuse you and waste your time, or can they be a valuable resource? Here are some things to consider....**Read More**

## HIPAA and why you need a health care proxy

In 1996, more than 25 years ago, Congress enacted the Health Insurance Portability and Accountability Act, which aims to safeguard people's private health care information. Keeping people's health care information private is important. But, HIPAA sometimes also keeps doctors and hospitals from sharing key information with you about the people you love. HIPAA provides all the more reason **everyone should have a health care proxy—** someone you designate, whom you trust, who can speak for you

and ensure your wishes are honored, when you cannot speak for yourself.

Without a health care proxy (sometimes called a "medical power of attorney" or an "advance directive,") your family has only **limited rights to make health care decisions on your behalf.** And, at times, doctors and other care providers are not aware of these rights or misunderstand them, preventing your family from making needed decisions. Stories abound of family members not



able to get information from the doctor about a loved one's condition because of HIPAA.

HIPAA does not keep this information from being shared in many cases, but doctors and hospitals often misapply it.

For your own peace of mind, make sure you and the people you love have signed health care proxies. They are state-specific. You can download them free **here.** With a signed health care proxy, you know that someone you trust can speak on your behalf if you're

hospitalized and unable to speak for yourself. Without a health care proxy, that person may not be able to help you at all.

Ideally, you should give a copy of your health care proxy to the person you have designated as your proxy as well as to your doctor. If you don't share it with the person, make sure your health care proxy knows where to locate it in your home. It's of no use if your proxy does not have a record of it. For more reasons why health care proxies are so important, click **here.**

## New Study Shows How Logging on to the My Social Security Site Will Benefit You

My Social Security (MySSA) is a key online resource offered by the Social Security Administration, yet the number of people with a MySSA account remains low. However, a new study shows that, for younger people especially, **MySSA could be a potentially useful financial and retirement preparedness tool,** by prompting individuals early and clearly about important information and actions for financial and retirement planning.

The study, which was done by

the University of Michigan's Michigan Retirement and Disability Research Center, finds that the strongest predictor both for having an account and the number of activities conducted on the MySSA platform is being a Social Security beneficiary.

In addition, internet literacy and educational levels also are important determinants of account ownership and usage, the study notes. There are four key reasons for not creating a MySSA account, according to



the study, including a lack of awareness of MySSA; no relevance/need; security and privacy concerns; and low internet/computer literacy.

However, when interviewees created or logged into an account, they found the MySSA platform to be clear, navigable and relevant.

According to the Social Security website, the account provides personalized tools for everyone, whether you receive benefits or not. For example, you can use your account to

request a replacement Social Security card.

If you do not receive benefits, the website enables you to get personalized estimates for future benefits, get estimates for your spouse's benefits, check the status of an application, or get your Social Security statement.

If you do receive benefits, the website enables you to set up or change direct deposit, get a Social Security 1099, opt-out of mailed notices, and change your address.

## Group Homes: Pros and Cons for Senior Care

Smaller and cozier than standard long-term care facilities, group homes may provide comparable care for some older adults.

You won't walk lengthy corridors with identical rooms, or see a calendar chock-full of structured activities – but you may smell a home-cooked meal. For some older adults who need long-term care, group homes are providing a more family-style alternative to **nursing homes** or **assisted living facilities**.

Also known as adult family homes or board and care homes, these relatively small residences are found in regular neighborhoods. Older adults who require help with their daily personal needs, and who may have dementia or cognitive impairment, live among peers with 24/7 assistance and supervision from caregivers. Some group homes offer skilled nursing care, similar to a nursing

home. Still, a home-like setting – not an institutional atmosphere – is a key attraction.

As with other long-term care options, group homes are licensed in their state and must meet certain standards. Staff members undergo mandatory yearly training, plus additional education and training by the facility.

Typically, group home care costs less than traditional long-term care options, particularly if you're paying for long-term care out of pocket. However, group homes aren't for everyone – but they're worth considering for older adults who can't live independently but still crave the feeling of being at home

### What Is a Group Home?

Group home definitions, licensure, costs, services, availability and even names vary from state to state. In Washington, for instance, adult family homes provide skilled



nursing care, in addition to personal caregiving and assistance with activities of daily living, for older adults.

"They're a good fit when people need more one-on-one assistance, particularly if they're a **fall risk** or need additional help with toileting or eating," says Lisa Mayfield, the founder of Aging Wisdom, a care management practice in the Seattle area, and a past president of the Aging Life Care Association. "Also, there are smaller settings to navigate, which can be an advantage as mobility decreases. They tend to be on one level, which makes navigating easier and safe."

Each home has a relationship with a nurse delegator, who can supervise and oversee nursing skills or tasks that residents require. In addition, residents have an array of health care services available, when needed.

"In our state, there are many

visiting medical providers that will visit the adult family home to provide the primary care onsite," Mayfield says. These homes can help coordinate care for residents with providers such as **primary care physicians**, physical and occupational therapists and extra nursing support. "You can even engage hospice support in adult family homes," she notes.

"More and more states are licensing group homes," says Sandy Markwood, the CEO of USAging, formerly known as the National Association of Area Agencies on Aging. "Typically, they're privately owned, so you really need to dig in to find out what services and supports they offer." As with any long-term care decision, she says, "There should be a lot of questions when you move someone into a group home situation."...**Read More**

## Will You Owe Taxes on Last Year's Stimulus Payment?

The third and largest stimulus payment arrived electronically in most Americans' bank accounts — or as checks or debit cards in the mail — last year as Uncle Sam's way of helping us get through the COVID-19 pandemic. It was worth \$1,400 per eligible person.

But now, a lot of people may be wondering whether they are going to owe extra taxes for receiving that payment. We don't say this often about the IRS, but the federal agency actually has some *good* news for taxpayers.

The IRS, which refers to stimulus payments as "economic impact payments," states in this year's **instructions** for filling out the Form 1040 tax return:

"Any economic impact payment you received is not taxable for federal income tax purposes ..."

Nor would the payment affect your income when determining whether you are eligible for federal assistance or benefits.

Why isn't the money taxable?



Because in the government's eyes, it's a tax credit. The payments most of us received last year were merely

advance payments of that credit, known as the recovery rebate credit.

So, the bottom line is that if you received your full third stimulus payment last year, you are good to go. You won't need to claim the credit on your tax form, and you won't owe the feds an extra penny.

If you didn't receive your full

stimulus payment, you can claim the recovery rebate credit on your 2021 return to get the remainder of the stimulus money that has been earmarked for you.

There is a line on the 2021 **Form 1040** tax return specifically for the recovery rebate credit. So, the tax software or tax professional you use this season likely will ask you exactly how much money you received for the third stimulus payment, in order to determine whether Uncle Sam owes you money for that tax credit.

## 'SIM swap' scams swiped \$68 million in 2021— here's how to protect yourself

The F.B.I. has issued a warning about the growing number of "SIM swap" scams that essentially steal someone's cellphone number to hack their personal data.

A "SIM swap" scam occurs when a criminal acquires a mobile phone's SIM card (aka **the memory card that identifies the phone's owner**) and connects the device to the mobile network) from an unknowing victim to steal personal information such as

"bank accounts, virtual currency accounts, and other sensitive information," according to the **public service announcement** from the FBI.

In many instances, criminals will use phishing techniques to obtain personal information about the victim, and then use it to impersonate the victim to their mobile carrier — and subsequently, switch the victim's phone number to a different SIM card.



"Once the SIM is swapped, the victim's calls, texts, and other data are diverted to the criminal's device," the FBI explains in its PSA. "This access allows criminals to send 'Forgot Password' or 'Account Recovery' requests to the victim's email and other online accounts associated with the victim's mobile telephone number." The FBI received 320 complaints related to SIM-swapping incidents between

January 2018 and December 2020, and the adjusted losses added up to \$12 million.

And the problem is getting worse. In 2021 alone, the FBI received 1,611 SIM-swapping complaints, with adjusted losses totaling more than \$68 million.

So what can you do to protect your phone and your personal information from SIM swap schemes? This is what the FBI recommends....**Read More**

## CDC Issues Proposed Changes to Opioid Painkiller Guidelines

(HealthDay News) -- Proposed changes to voluntary federal guidelines for prescribing opioid painkillers emphasize that doctors should first try other treatments for acute and chronic pain.

The non-opioid treatment options suggested by the U.S. Centers for Disease Control and Prevention include prescription medications like **gabapentin** and over-the-counter painkillers like ibuprofen (Advil, Motrin), as well as physical therapy, massage and acupuncture, *The New York Times* reported.

"The evidence around the long-term benefits of opioids continues to remain very limited," Christopher Jones, a co-author of the draft guidelines,

told the *Times*.

The proposed changes dovetail with a nationwide epidemic of **opioid use** and **overdose deaths**. Between 1999 and 2019, nearly 500,000 Americans died of an overdose from any opioid, including illicit and prescription drugs.

The revisions represent the first comprehensive rewrite of the CDC's opioid prescribing guidelines since 2016. Like the current guidelines, these are recommended practices and not mandatory.

The 12 recommendations remove suggested limits on doses for chronic pain patients, encouraging doctors to use their best judgment.



The draft document attempts to balance the need for using opioids to treat severe pain and reducing patients' risks from the drugs. It warns of addiction, depressed breathing, altered mental status and other dangers associated with opioids, the *Times* reported.

The CDC also pointed out that **opioids** play an important role in easing immediate, acute pain from traumatic injuries.

When doctors feel the need to prescribe them, the proposed guidelines say they should begin with the lowest effective dose and prescribe immediate-release pills instead of long-acting ones.

The public has 60 days to comment on the proposed

recommendations through the Federal Registry.

The CDC aims to release a final version of the updated guidelines by year's end. The *Times* noted they do not apply to patients with pain from cancer or sickle cell disease, or those who are in end-of-life palliative care.

"We are welcoming comments from patients who are living with pain every day and from their caregivers and providers," said Jones, acting director of the National Center for Injury Prevention and Control, the arm of the CDC that released the proposed guidelines.

## Regular Use of Acetaminophen Tied to Higher Heart Risks

Acetaminophen may do wonders for a headache, but using it for long-term pain relief could prove risky for people with high blood pressure, a new clinical trial suggests.

Over two weeks of use, the painkiller caused blood pressure to spike in people who already had elevated numbers, the researchers found. That was true whether they were on blood pressure medication or not.

The findings — published Feb. 7 in the journal *Circulation* — strengthen evidence that acetaminophen (Tylenol) can

raise blood pressure when it's taken regularly.

But the study findings may also leave people with heart disease, or risk factors for it, with more questions about how to deal with long-lasting pain.

That's because **other common painkillers** — nonsteroidal anti-inflammatory drugs (NSAIDs) like ibuprofen (Motrin, Advil) and naproxen (Aleve) — are already known to raise blood pressure. What's more, they are linked to an increased risk of heart disease and stroke when used long-term.

Experts said it's not clear



whether acetaminophen carries the same heart and stroke risks as NSAIDs. But the blood pressure rise seen in this trial is concerning. "Especially in people who already

have **hypertension** [high blood pressure], an increase in blood pressure is always bad," said Dr. Donald Lloyd-Jones, president of the American Heart Association and chairman of preventive medicine at Northwestern University Feinberg School of Medicine, in Chicago.

"This trial certainly gives us important information," added

Lloyd-Jones, who was not involved in the research.

He said doctors should ask patients about use of acetaminophen and other medications whenever their **blood pressure** is hard to control.

And if patients do need to take acetaminophen for chronic pain, Lloyd-Jones said, their blood pressure should be carefully watched, with the help of home monitoring.

"We want to detect any blood pressure changes early, so we can respond appropriately," he said.... [Read More](#)

## Clutter in the Attic: Why Memory Falters With Age

Only maybe you get distracted by another, more enticing item from your past. Or you find the object you're seeking but it's intertwined with six similar items, and withdrawing the one will drag out the entire tangle.

That's how an **old person's memory** works, a new theory claims.

Seniors struggle with memory not because they have trouble remembering things, but because their minds are too overloaded with a lifetime's worth of memories.

"There's this prevalent idea that older adults' memories are kind of impoverished, or they have weak memories that do not contain a lot of information," said Tarek Amer, a postdoctoral research fellow at Columbia and Harvard universities, and lead author of a new paper in *Trends in Cognitive Sciences* that explains this new theory.

"But based on a lot of evidence, we're actually arguing the opposite. Older adults store too much information, so in a



sense they have a harder time focusing their attention on one piece of target information and exclude all sorts of other distractions," he added.

When anyone attempts to access a memory, their brain quickly sifts through everything stored in it to find the relevant information, Amer and his colleagues write.

Young people don't have as much prior knowledge tucked away in their brains, so it's easier for them to find the memory

they're seeking without being distracted by irrelevant recollections.

But older people have to dig through a huge amount of prior knowledge when looking for a specific memory.

It's more difficult for older folks to suppress irrelevant reminiscences, and they often pull out a gob of other memories that are stuck to the one they sought, according to behavioral and brain imaging studies cited by the researchers.... [Read More](#)

## 1 in 3 Adults With COVID Develops Other Health Issues Later: Study

(HealthDay News) -- Nearly one-third of older COVID-19 survivors develop new health problems in the months after their infection, a new study finds.

Those conditions involve a number of major organs and systems, including the heart, kidneys, lungs and liver, as well as mental health problems.

With roughly 400 million people infected with the coronavirus worldwide, "the number of survivors with [new conditions] after the acute infection will continue to grow," wrote study author Dr. Ken Cohen and colleagues. Cohen is executive director of

translational research at Optum Labs, which is based in Minnesota.

The researchers analyzed 2020 health insurance data from more than 133,000 Americans 65 and older who were diagnosed with COVID before April 1, 2020.

They compared them with groups of people 65 and older from 2019 and 2020 who did not have COVID, and a group diagnosed with viral lower respiratory tract illness.

Among the COVID patients, 32% sought medical attention in the several months after their diagnosis for one or more new or persistent health conditions,



which was 11 percentage points higher than the 2020 comparison group.

The researchers found the COVID patients had a higher risk for a number of conditions, including respiratory failure, fatigue, high blood pressure and mental health diagnoses.

And compared with the viral lower respiratory tract illness group, the COVID patients had a higher risk of respiratory failure, dementia and fatigue.

Looking at just the COVID patients, the highest risk for several new health problems was seen in those admitted to the hospital, men, Black patients, and those 75 and older,

according to the study. The findings were published Feb. 9 in the [BMJ](#).

This was an observational study, so it can't prove a direct link between COVID-19 and new health problems, said Cohen's team.

Still, these findings further highlight the wide range of important conditions that may develop after infection with COVID, the authors said in a journal news release.

"Understanding the magnitude of risk" might enhance their diagnosis and the management of patients with new problems after COVID infection, they said.

## A Non-Opioid Way to Pain Relief After Knee, Shoulder Surgeries

Two new studies on pain relief suggest there is a safer alternative to addictive opioid painkillers after knee and shoulder surgery.

The findings dovetail with changes to voluntary [federal guidelines](#) for prescribing opioid painkillers proposed by the U.S. Centers for Disease Control and Prevention last week. The proposal urges doctors to prescribe non-opioid therapies whenever possible.

"These studies demonstrated that an alternative non-opioid pain regimen was just as effective in managing postoperative pain following ACL and rotator cuff surgery compared with traditional opioid medication," said Dr. Kelechi Okoroa, lead author of

both studies. He's an orthopedic surgeon at the Mayo Clinic's orthopedics and sports medicine facility in Minneapolis.

In [one study](#), 62 patients had knee surgery to reconstruct their anterior cruciate ligament (ACL), and the [second study](#) included 40 people who had surgery to repair the rotator cuff in their shoulders.

Everyone received a nerve block before surgery. In both studies, one group received an opioid for pain, while the other received non-opioid pain relievers such as acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), muscle relaxants, and/or drugs targeting nerve



pain.

Both studies found the non-opioid regimen provided as much -- if not more -- pain control and satisfaction as opioids for the first 10 days after surgery.

The various medications target different types of pain, Okoroa said.

"Acetaminophen and NSAIDs are used to target the pain cascade and postoperative inflammation, respectively," he said. "Gabapentin is used to address nerve-related pain and methocarbamol [Robaxin] can control muscle cramps and spasms."

This strategy eliminates the use of opioids, which are highly addictive and have led to a nationwide [epidemic of](#)

[overdoses](#). Orthopedic and spine conditions account for about 3 in 10 opioid prescriptions, Okoroa said.

The new approach may also help people undergoing other types of surgery to avoid opioids and their risks, he said.

"The regimen has been found to be effective in common sports surgeries but could be expanded to a wider range of procedures," Okoroa said.

In both studies, the most common side effects were drowsiness, dizziness and gastrointestinal symptoms. In the shoulder study, participants who received the non-opioid regimen reported fewer side effects than those who took opioids... [Read More](#)

## Is Sleep Apnea CPAP Useless for Folks Over 80?

It's called CPAP for short, and the treatment helps millions with [sleep apnea](#) breathe better at night. But new research suggests it might not make any difference for patients over 80.

"By all the measures we tried, whether it was sleepiness, quality of sleep, blood pressure, depression or anxiety, we found no significant difference between the people [over 80] who used it and the people who didn't," said researcher Dr. David Gozal. He is chair of the department of child health at the University of Missouri's School

of Medicine, in Columbia, Mo.

Often, untreated sleep apnea can lead to high blood pressure, heart trouble, depression or anxiety. Studies have shown that continuous positive airway pressure ([CPAP](#)) can significantly reduce sleepiness and depression, and prevent high blood pressure, the researchers noted.

It's not clear why CPAP didn't help these older patients, Gozal said. It's possible that people over 80 have disturbed sleep due to other reasons or conditions



that aren't caused by sleep apnea. For example, CPAP doesn't treat high blood pressure not caused by apnea, he explained.

Also, these older patients may have developed other ways of coping with conditions like [depression](#) and [anxiety](#) that make treating sleep apnea unnecessary, he added.

For the study, Gozal's team followed nearly 370 patients with sleep apnea who were over 70 years of age and were assigned to CPAP therapy or no

therapy for three months.

The investigators found that among patients over 80, CPAP did not have much effect on sleep apnea. Although patients using CPAP had significantly improved snoring and witnessed apnea, there were no improvements in apnea-related symptoms, such as depression, anxiety or [blood pressure](#) levels.

The findings were published recently in the journal [Sleep Medicine](#). ...[Read More](#)



## FDA Approves New Antibody Drug to Fight Omicron Variant

(HealthDay News) -- The U.S. Food and Drug Administration on Friday gave the nod for a new monoclonal antibody treatment that works against the **Omicron variant**.

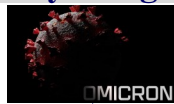
The emergency use authorization for bebtelovimab is for the treatment of mild to moderate COVID-19 in adults and pediatric patients at least 12 years of age who are at high risk for severe disease. Eli Lilly and Co. produces the treatment. On Thursday, Lilly **announced** that the United States would purchase 600,000 doses of the drug in a \$720 million deal.

The emergency use authorization comes as good news for people at high risk for severe COVID. The mutations of Omicron had rendered

ineffective some of the previously available monoclonal antibody treatments, leaving doctors with fewer treatment options.

"Today's action makes available another monoclonal antibody that shows activity against Omicron, at a time when we are seeking to further increase supply," Dr. Patrizia Cavazzoni, director of the FDA's Center for Drug Evaluation and Research, said in a **statement**. "This authorization is an important step in meeting the need for more tools to treat patients as new variants of the virus continue to emerge."

Bebtelovimab works by binding to the spike protein of the virus that causes COVID-19,



similar to other monoclonal antibodies that have been authorized for the treatment of high-risk patients, the FDA said.

The agency based its decision on a series of clinical trials involving more than 700 COVID patients. The rates of hospitalization and death seen in those who received bebtelovimab alone or with other monoclonal antibodies were generally lower than those of a group that received a placebo, the FDA said.

"Lilly has worked hard to fight this pandemic. Early in 2021, prior to the identification of the Omicron variant, Lilly scientists were already working to develop bebtelovimab as a broadly

neutralizing antibody that could be used to fight a highly mutated variant, should one emerge," Dr. Daniel Skovronsky, Lilly's chief scientific and medical officer and president of Lilly Research Laboratories, said in a **company statement**.

"With the emergence of variants such as Omicron, treatment options remain limited. Lilly is pleased to provide another treatment option to help address the ongoing needs of patients and health care providers who continue to battle this pandemic," Skovronsky said.

Possible side effects of bebtelovimab include itching, rash, infusion-related reactions, nausea and vomiting.

## Winter Weather Can Bring Dry, Cracked Heels. Expert Offers Help

(HealthDay News) -- Dry, cracked heels are common in the winter, but there are several ways to prevent and treat the problem, a skin specialist says.

"Cold, dry weather, walking barefoot, and long, hot showers are just some of the reasons why you may have dry, cracked heels this winter," dermatologist Dr. Patrick Blake said in an American Academy of Dermatology news release.

"Understanding what causes dry, cracked heels and taking steps to prevent them can relieve the itch and pain that

they can cause and leave you with softer, healthier skin this winter," he added.

Blake offered a number of tips:

- Limit baths and showers to five to 10 minutes. Bathing or showering for too long can dry out your skin and make dry, cracked heels worse. Gently blot your skin dry with a towel.
- Use a gentle, fragrance-free cleanser to help your feet retain their natural oils.



- Moisturize within five minutes of bathing with a moisturizing cream that contains 10% to 25% urea, alpha hydroxy acid or salicylic acid. Apply it immediately after bathing and whenever your heels feel dry.
- Before bed, apply plain petroleum jelly to your heels. It's a good idea to wear socks to protect your bedding.
- Apply a liquid bandage over heel cracks during the day to create a protective barrier that can help reduce pain, speed

healing, and block germs from getting into your skin.

- Wear proper footwear. If you have dry, cracked heels, avoid open-heeled shoes such as flip-flops or slingbacks, worn-down shoes, or shoes that don't fit properly.

"Sometimes, cracked heels are caused by a medical condition, such as diabetes," Blake said. "If your dry, cracked heels are severe or do not improve after following these tips, talk to a board-certified dermatologist."

## Feel Dizzy When You Stand Up? Two Simple Steps Might Ease That

Almost everyone has had a dizzy spell after standing up too quickly, but some people suffer them regularly. Now, a new study suggests two do-it-yourself ways to help.

The study focused on what's called initial **orthostatic hypotension** (IOH), where a person's blood pressure drops sharply within 30 seconds of standing up from sitting or lying down.

The problem is short-lived, and the body rights itself within about a minute. But the symptoms — including dizziness, blurred vision and nausea — can be troubling and sometimes lead to falls.

In the new study, researchers tested two simple maneuvers for thwarting those symptoms: activating the lower-body muscles right before or right after standing.

It turned out that both approaches helped, at least for the 22 young women in the study. Doing either one limited the women's **blood pressure drops** when they stood up from sitting.

But more importantly, their symptoms were eased, said senior researcher Dr. Satish Raj, a professor of cardiac sciences at the University of Calgary's Cumming School of Medicine.



"We showed that people feel better, which is what they care about," Raj said.

The general term orthostatic hypotension (OH) refers to a decline in blood pressure after a person stands up. But there are different forms of OH, including IOH, Raj explained.

In IOH, the blood pressure drop is particularly dramatic — at least 40 mm Hg in **systolic pressure** — and it strikes within 15 to 30 seconds of standing up. It also resolves quickly thereafter.

"Classical" OH has a somewhat slower onset, within about 3 minutes, and the blood pressure

reduction is more sustained. It's common among elderly people, especially when they have health conditions

like **diabetes** or **heart disease**. With IOH, Raj said, "we see it a lot in younger people, and fundamentally healthy people."

Whenever a person stands from sitting, there is some shift of blood flow toward the belly and legs. It's thought that IOH involves a rapid and excessive dilation of blood vessels in the lower body, which results in a temporary reduction of blood flow to the brain. Soon thereafter, symptoms like light-headedness and seeing spots surface....**Read More**

## Women Should Take These 3 Things to Heart

(HealthDay) February is American Heart Month — the perfect time to remind women of three things they need to know about heart disease.

It's the **leading cause of death** among U.S. women, accounting for one in three deaths, according to the American Heart Association (AHA). While progress to reduce that rate has been made in the past 20 years, improving risk factors and death rates in women under 50 has been slow going.

That's why the AHA is calling on women to do three things: Recognize the signs of a heart attack; understand their heart disease risk factors; and make healthy lifestyle changes to prevent heart disease.

**No. 1: Know that heart attack symptoms in men and women can differ.** Chest pain is the leading symptom in both, but in women it may not be the only or predominant symptom,

according to Dr. Rekha Mankad, a cardiologist and director of the Mayo Clinic Women's Heart Clinic in Rochester, Minn.

"Chest pain is there, but it may not double you over. The pain may be in the jaw, radiate around to the back or go up the neck. A woman might have shortness of breath, might feel sick to her stomach or break out in a sweat," Mankad said in a Mayo Clinic news release. "Women experiencing a heart attack may be fatigued and often have an overwhelming feeling of unease — that something is not right."

Women often ignore these symptoms because they doubt they could be having a heart attack. A 2019 AHA survey found that only 44% of respondents knew that heart disease is the leading cause of death for women.

**No. 2: Know your risk for heart attack and stroke.** These



include age, high blood pressure, diabetes, a concerning cholesterol profile, and smoking or vaping.

A cholesterol profile that is high in "bad" low-density lipoprotein (LDL) cholesterol and triglycerides — fats in the blood — increases the risk of heart disease for both sexes.

Women are more likely than men to have high blood pressure as they age, so they should watch for changes, because high blood pressure could put more strain on the heart, arteries and kidneys. It also increases the risk of stroke. Women who have diabetes or smoke are at a higher risk for heart disease than men who do.

It's also important for women to pay attention to complications such as gestational diabetes, elevated blood pressure during pregnancy or preterm labor delivery, because they can increase the risk of heart disease

later in life.

Any of these risk factors should be shared and discussed with a health care professional, Mankad said.

**No. 3: Reduce your risk.** To help prevent heart disease, take action to manage blood pressure, control cholesterol, reduce blood sugar, get daily physical activity, eat a healthy diet, lose weight and stop smoking.

"Quitting smoking or stopping vaping is one of the best things you can do for your heart," Mankad said.

"The most sustainable changes often start small," she added. "As little as 10 minutes of walking or activity each day can boost mood and start a healthy habit to build upon. Replacing one processed food with a more nutritious whole grain, fruit or vegetable, and choosing olive oil over hydrogenated oils all have a positive impact on heart health over time."

## Apps Can Help Keep Older Folks Healthy — But Most Don't Use Them

Mobile health apps can help older Americans but only about four in 10 use them, and those most likely to benefit are least likely to take advantage of them, a new survey reveals.

Health apps monitor everything from calories and exercise to blood pressure and blood sugar to help users manage chronic conditions or achieve health goals.

"Now that most older adults have at least one mobile device, health-related apps can provide an opportunity to support their health-related behaviors, manage their conditions and improve health outcomes," said Dr. Pearl Lee, a geriatrician at Michigan Medicine-University of Michigan

who worked on the poll report.

But this phone poll of more than 2,100 Americans between 50 and 80 years of age found that only 44% had ever used a health app on their smartphone, tablet or wearable device.

Respondents who were least likely to have done so included those in poor health and those with lower levels of education or income, according to the **National Poll on Healthy Aging** from the University of Michigan Institute for Healthcare Policy and Innovation.

People with incomes over \$100,000 were nearly three times more likely than those with



incomes under \$30,000 to use health apps (43% versus 15%). Those with college degrees were more than twice as likely to do so than those who had not completed high school.

Half of those who never used a health app or who stopped said they have no interest in doing so, the findings showed.

**Many apps** can be useful to seniors, according to AARP and **Senior Living.org**, an organization for older people and their caregivers.

In all, 28% of respondents in the new poll said they currently use at least one health app. One-third said they use an app to track their physical activity, while

smaller numbers use apps to keep tabs on sleep, weight, nutrition or blood pressure, to guide meditation, or manage mental health and stress.

One-quarter of current users said they have shared information from their apps with their health care providers, according to a news release from Michigan Medicine.

Among respondents with diabetes, only 28% said they use an app to record their blood sugar levels while 14% use an app to log their medications. Nearly half of respondents with diabetes said they would be interested in using an app in both ways... **Read More**

## AHA News: Does Kindness Equal Happiness and Health?

Could kindness be a magic elixir that makes us happier — and healthier?

Research suggests acts of kindness like donating money, volunteering and mentoring can boost the giver's emotional health, but science also is studying how altruism improves physical health.

Acts of kindness can take many forms, especially amid

Random Acts of Kindness Week from Feb. 13-19. It can be as simple as holding a door for someone, to a commitment like donating blood or starting a fundraiser. (The Random Acts of Kindness Foundation has many ideas to get you going.)

The main takeaway is they promote social connection, said Sonja Lyubomirsky, a



psychology professor at the University of California, Riverside. That's especially important during the pandemic as people have become more isolated.

"They can strengthen relationships, help you make new friends, give you a more positive, optimistic outlook and enable you to feel good about yourself," said Lyubomirsky.

Even just recalling acts of kindness could promote well-being. Lyubomirsky led a 2019 study published in the Journal of Positive Psychology showing that when participants recalled hugging a grandparent or buying lunch for a co-worker, for instance, their well-being improved as much as when they performed the act... **Read More**